Care & Service Utilization

Updated September 2011

The Ryan White HIV/AIDS Program is designed to assist individuals living with HIV/AIDS who lack the financial and/or health coverage resources to treat their HIV disease. The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009) was first enacted in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. It has been amended and reauthorized four times (1996, 2000, 2006, and 2009) to reflect new and emerging needs (HRSA, 2011). Funds are distributed across the United States through part areas (see next page). Virginia receives funds through Parts A, B, C, D, and F from the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA). The Virginia Department of Health (VDH) administers Part B funds for the entire State.

RYAN WHITE PART B IN VIRGINIA

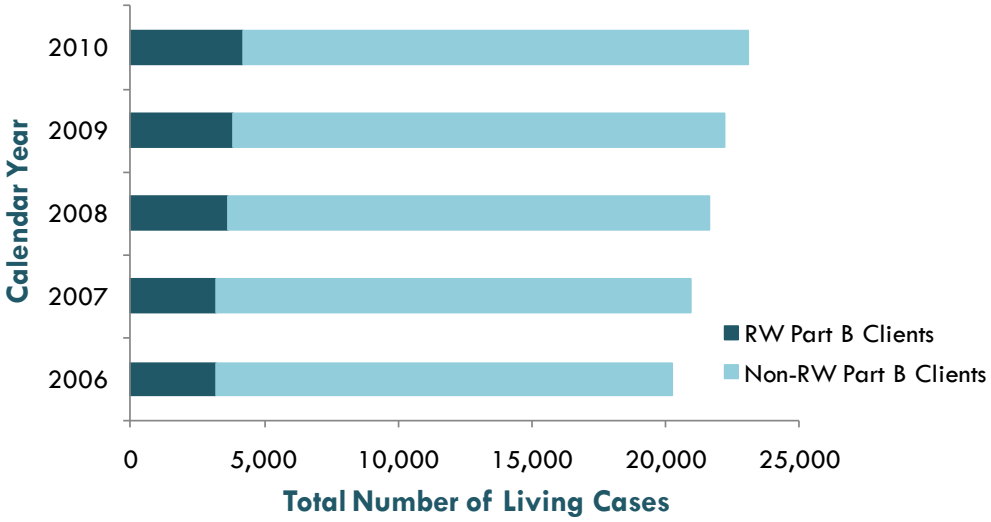
Demographics

All Ryan White Part B data for Virginia is housed in the Virginia Client Reporting Center Database (VACRS) which is maintained for VDH by the Virginia Commonwealth University (VCU) Survey Evaluation and Research Laboratory (SERL).

Between January and December 2010, 4,206 clients were reported to have received care funded by Part B. These clients represent approximately 18% of the 23,088 people estimated to be living HIV/AIDS in Virginia as of December 31, 2010. While the number of estimated persons living with HIV/AIDS in Virginia has grown at a steady rate, the number of Ryan White Part B clients has outpaced that growth from 2008-2010.

Part B clients were primarily between the ages of 35-54 (60%) and Black (58%). These numbers are similar to the demographics for people estimated to be living with HIV/AIDS (PLWHA) in Virginia as of December 31, 2010 who were primarily between the ages of 35-54 (61%) and Black (60%). The Ryan White Part B client population had a lower percentage of males (66%) than the PLWHA population (74%). Clients who reported being Hispanic or Latino made up a slightly higher percentage of the Part B population (7.8%) than Virginia PLWHA (6.8%). Ryan White Part B client demographics have been consistent for the last five calendar years. Of the 4,206 Ryan White Part B clients in CY 2010, 2,407 (57.2%) had incomes that were equal to or below the Federal Poverty Level (FPL); an additional 1,015 (24.1%) had incomes between 101% and 200% of the FPL.

Ryan White Part B Clients as Portion of Living HIV/AIDS Cases in Virginia, 2006-2010



Ryan White Funding Sources in Virginia

Ryan White Section	Description of eligible grantees	Grantees
Part A	Funds eligible metropolitan areas (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent 5-year period, and transitional grant areas (TGAs), those with 1,000-1,999 reported AIDS cases over the most recent 5-year period. At least 75% of all Part B funds must be expended for core medical services*. Funds are also available for Minority AIDS Initiative that strengthens organizational capacity to expand HIV-related services in minority communities.	Norfolk TGA (Coverage area: Chesapeake, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg, and York) Washington, D.C. EMA (Virginia localities covered: Alexandria, Arlington, Clarke, Culpeper, Fairfax, Fairfax (City), Falls Church, Fauquier, Fredericksburg, King George, Loudon, Manassas, Manassas Park, Prince William, Spotsylvania, Stafford, and Warren)
Part B	Funds States. This includes base and supplemental grants, ADAP and ADAP supplemental grants, and Emerging Communities (EC) grants. In Virginia, the majority of services are provided through four regional consortia that plan and deliver HIV care. At least 75% of all Part B funds must be expended for core medical services*. Funds are also available for Minority AIDS Initiative that strengthens organizational capacity to expand HIV-related services in minority communities.	Virginia Department of Health
Part C	Funds Early Intervention Services to reach people newly diagnosed with HIV and ambulatory care.	Carilion Centra Health Inova Health System, Juniper Program Mary Washington Healthcare University of Virginia Virginia Commonwealth University
Part D	Funds family-centered primary and specialty medical care and support services for women, infants, children, and youth with HIV/AIDS.	Inova Health System, Juniper Program Virginia Commonwealth University
Part F	Special Projects of National Significance (SPNS) that funds innovative models of care and supports the development of effective delivery systems for HIV care. AIDS Education & Training Centers (AETC) that provide education and training for health care providers who treat people with HIV/AIDS. Funds oral health through the Dental Reimbursement Program and the Community-Based Dental Partnership Program.	Virginia Commonwealth University (AETC and SPNS) Virginia Department of Health (SPNS) Inova Health System, Juniper Program (AETC and SPNS)

* Core services include outpatient and ambulatory medical care (including labs); AIDS pharmaceutical assistance; oral health services; early intervention services; health insurance premium and cost-sharing assistance; home health care; home and community-based health services; hospice care; mental health services; medical nutrition therapy; medical case management; and substance abuse treatment-outpatient. The remaining 25% can be spent on support services including non-medical case management; outreach; medical transportation; linguistic services; respite care for persons caring for indi-viduals with HIV/AIDS; and referrals for health care and other support services.

Service Utilization

As stated earlier, Ryan White legislation requires that 75% of all Part B funds must be expended for core medical services. It is also important to note that in most instances, an individual Ryan White part does not account for all aspects of care for a client. Figure A below is the statewide core service utilization for Ryan White Part B clients in 2010: 55% (2,326) of clients received ambulatory/ outpatient medical care and 54% (2,280) of clients received medical case management during that same time period.

Figure B below shows service utilization trends from January 1, 2006 - December 31, 2010 for the two most utilized core services (ambulatory/ outpatient medical care and medical case management) and the two most utilized support services (medical transportation services and non-medical case management). Overall, service utilization has continued to rise in these areas during this time. The substantial change in medical case management and non-medical case management reported services, starting in 2006, were due to statewide technical assistance provided to service contractors by the Virginia HIV/ AIDS Resource and Consultation Center, to better understand Ryan White case management standards.

Figure A. Statewide Ryan White Part B Clients Served by Core Service Category, Jan 1 - Dec 31, 2010

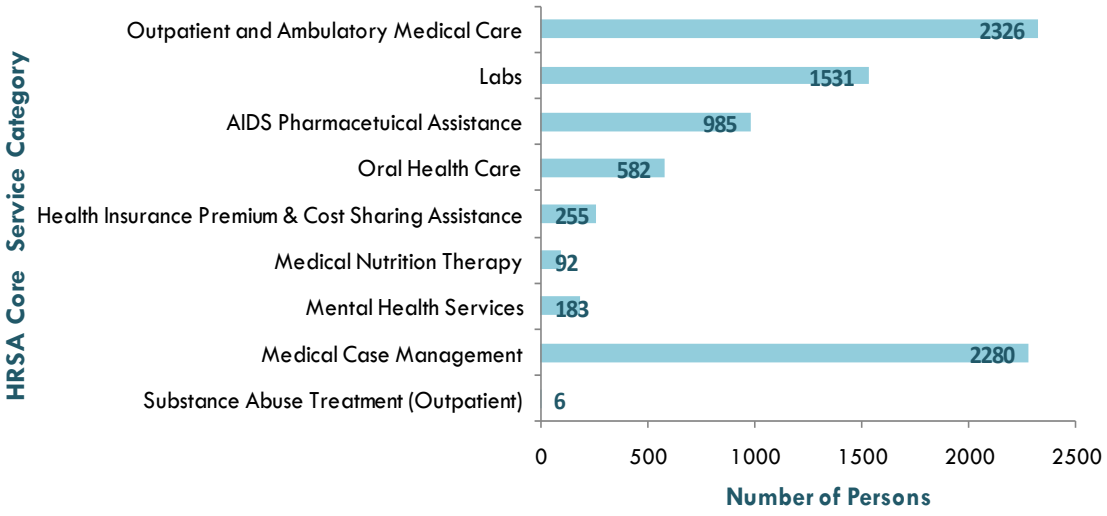
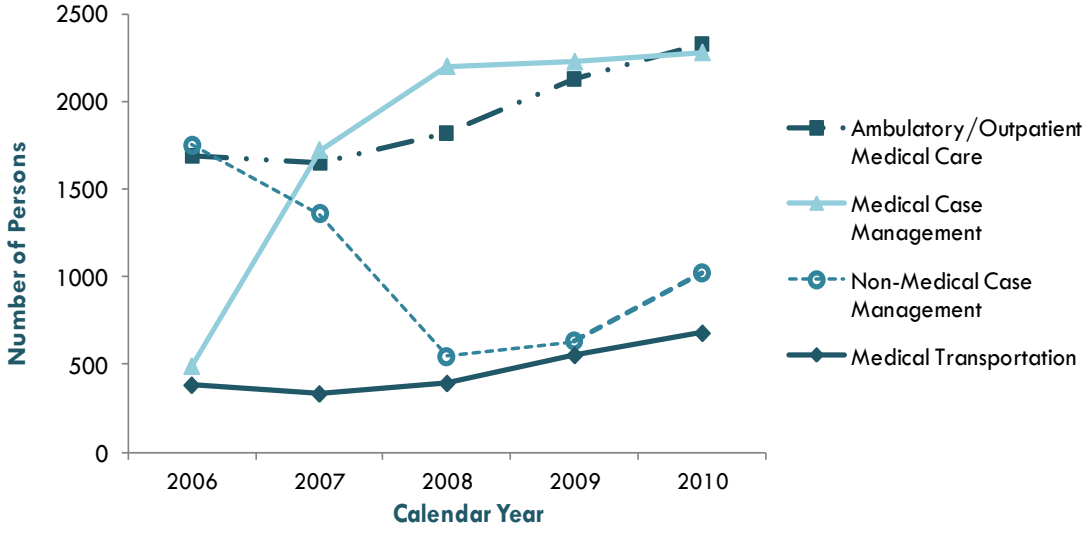


Figure B. Ryan White Part B Service Utilization by Clients, 2006-2010



AIDS Drug Assistance Program

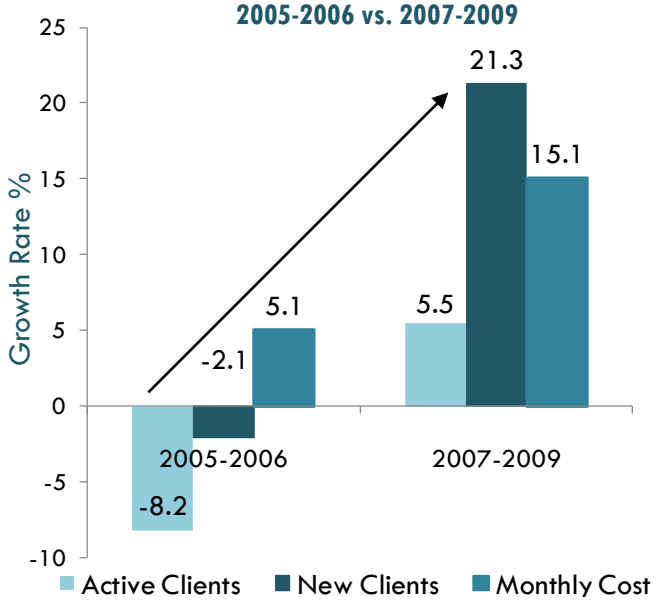
The Virginia AIDS Drug Assistance Program (ADAP), administered by VDH, has a formulary that includes antiretrovirals, vaccines, and selected medications to treat or prevent opportunistic infections (OIs). Eligible clients must have incomes at or below 400% of the FPL; however, the majority of enrolled clients in 2010 (89%) had incomes below 200% FPL during CY 2010.

During Ryan White Part B grant year 2009 (April 1, 2009-March 31, 2010), 3,952 clients received 63,959 prescriptions, representing a steep increase in utilization of the program. Pharmaceutical expenditures reached a historic high of $26,290,325, a $3.2 million increase from the prior year. In grant year 2010 (April 1, 2010-March 31, 2011), 3,958 clients received 66,076 prescriptions and pharmaceutical expenditures decreased to $23,611,626. This decrease was due to the implementation of aggressive cost containment measures including limiting prescriptions to 30 days per fill, disenrollment of clients who had not received prescriptions in over 5 months, and enrollment restrictions to three critical groups: 1) pregnant women, 2) children 18 and under, and 3) those receiving treatment for an active OI.

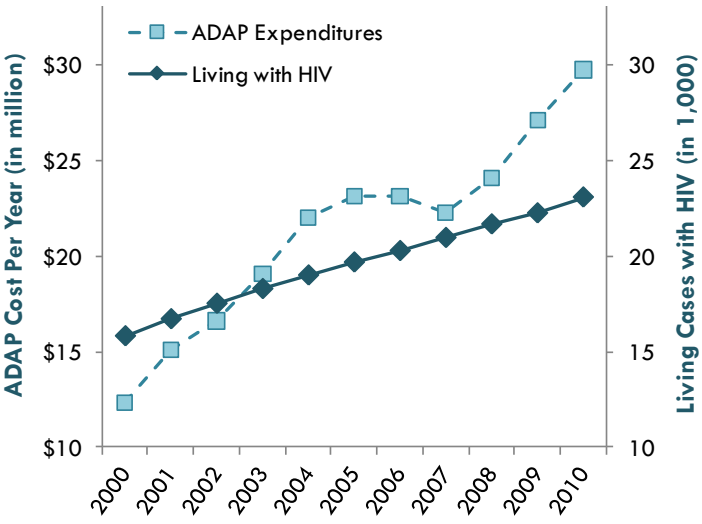
A waitlist was instituted in November 2010 for all those who were not in these three groups but did meet the previous enrollment criteria; 247 clients were transitioned from the program to other payer sources for medications. The need to develop cost containment strategies and, subsequently, a waitlist were driven by minimal increases in federal appropriations, fluctuations in state funding, increased program demand due to unemployment, heightened national efforts on HIV testing and linkages into care, high drug costs, and new HIV treatment guidelines calling for earlier therapeutic treatments. Both clients and monthly cost increased dramatically from 2007 to 2009, as compared to the change between 2005 and 2006.

Further evidence of the disproportionate impact on ADAP is illustrated by comparing the number of Virginia PLWHA (23,088) with the number of ADAP clients served in RW CY 2010 (3,958). Both of these figures are based on the last RW Part B grant year and demonstrate that Virginia ADAP provides treatment access to 17% of the known HIV/AIDS cases in Virginia. ADAP medication expenditures have increased more rapidly than the number of living cases. While the PLWHA population increased 3.7% from 2009 to 2010, ADAP cost increased 9.9% for that same time period. The steep increase in ADAP monthly cost and newly enrolled clients is mirrored in a dramatic increase of annual program expenditures, which outpaced resources.

Virginia ADAP's Growth Rates by Active Clients, New Clients, and Monthly Costs 2005-2006 vs. 2007-2009

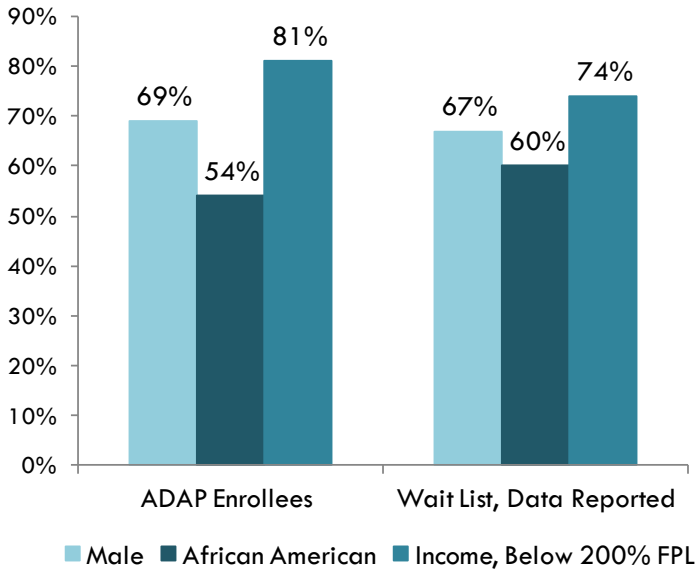


ADAP Expenditures and Living HIV Cases, Virginia, 2000-2010



As of July 1, 2011, the ADAP waitlist had 850 persons on it. The wait list population is similar to the ADAP population when comparing gender, race, and income. The majority of clients are male and Black/African American. Income trends are also similar for ADAP enrollees and wait listed clients.

Demographics for Virginia ADAP and Virginia ADAP Waitlist, 2010



REFERENCES

HRSA HIV/AIDS Programs. (2011) "About the Ryan White HIV/AIDS Program." Accessed August 2011: http://www.hab.hrsa.gov/abouthab/aboutprogram.html

HIV CARE SERVICES DATA SOURCES:

Care and Service Utilization data come from the Virginia Client Reporting Center Database (Ryan White Part B Data) and the AIDS Drug Assistance Program Database.

HIV/AIDS Prevalence data and associated demographics come from the eHARS database. Data for 2010 is preliminary and may be incomplete due to reporting delays.